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Fisk, M.

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Surveillance Technologies in Care Homes: Seven Principles for their Use

Abstract

Purpose – *This paper considers the use of surveillance technologies in care homes and the way in which they can help protect older people. It signals an ethical way forward for their use and helps de-fuse the heightened rhetoric associated with concerns about abuse. Seven principles are put forward by which the use of surveillance technologies can be supported.*

Design/methodology/approach – *The paper recognises the significance of technological developments and the part they play in helping people live more independently. For surveillance technologies, important ethical considerations must be taken into account, notably around the way in which concerns for privacy are balanced with people's safety and autonomy.*

Findings – *The paper points to an approach that guides the use of surveillance technologies within care homes. It begins to mediate between the positions of those who argue the merits of such technologies and those who point to some of them, notably cameras, as undermining people's privacy and eroding trust within care relationships. It is recognised that building on the seven principles will necessitate further work to take account of a wider range of views in relation to some specifics around surveillance technologies and their use.*

Originality/value – *The subject matter of the paper is important because of the attention being given to abuse in care settings; and the freedom by which anyone can access surveillance technologies. The paper is timely and carries substantial originality.*

Keywords – *Surveillance, Cameras, Assistive Technology, Telehealth, Privacy, Ethics*

Paper type – *Research Paper*

Poor Care and Abuse

On 30th April 2014 the BBC broadcast 'Behind Closed Doors: Elderly Care Exposed'. The Panorama programme in question reported on the use of hidden cameras to provide evidence of abuse in a number of care homes in England. The programme shocked its viewers who were entitled to believe that care homes were safe havens.

This and other exposés have prompted discussion as to how it is possible to minimise the occurrence of abuse. The discussion has followed what Biggs and Powell (2000) called an 'accelerating' and Ash (2014) an 'explosion' of interest in and attention to abuse, notably of adults deemed vulnerable.

Other countries have similar concerns. In the United States, the July 2011 eNews Bulletin of the National Centre for Elder Abuse, following the use of cameras in care homes by family members, opined that 'surveillance cameras may be one way to strengthen the presence of a capable guardian'. Three US states were reported by Jan Hoffman, in the New York Times of 18th November 2013, as explicitly permitting 'residents in long-term care facilities to maintain surveillance cameras in their rooms' with other states considering similar legislation. If there is to be such camera use, noted Mark Lachs in the Huffington Post of 22nd April 2014, it should have 'everyone's consent and knowledge' with standards in place to define 'how and when these devices should be employed'. In Australia it was reported by Julia Meadow, in The Age on 13th June 2012, that over twelve months '64 per cent of 1815 allegations of physical and sexual abuse in aged-care facilities were made

against staff.’ She noted that some charitable organisations were campaigning in favour of the use of cameras because of such abuse.

The images captured by hidden cameras and the linked exposés have naturally resulted in upset and anger. And the simple fact of their having identified abuse has been argued as justification for their usage. But arguments that offer unqualified support for the use of cameras may reflect a way of thinking that regards them as ‘all-seeing’ and, perhaps, as the primary or only type of surveillance technology that has a role to play. Cameras are, however, part of a wide range of technologies that can contribute to people’s protection. They should not, therefore, be the sole focus of attention. There are, therefore, questions that need to be addressed regarding

- (a) the overall legitimacy of surveillance in care homes;
- (b) the manner of use of different technologies to assist in the provision of care; and
- (c) the way that information gathered through surveillance technologies is stored and used.

The UK Debate

This paper argues that the use of surveillance technologies, including cameras, in certain locations within care homes is legitimate and ethically defensible. However, a range of considerations and pre-conditions must apply including recognition of the need for their use within appropriate safeguarding frameworks. Such frameworks require individuals to be ‘empowered to make choices and supported to manage risks’ with there being ‘zero-tolerance’ to abuse; a well-trained workforce; and a range of options to keep people safe that is ‘tailored to people’s individual needs’ (Faulkner and Sweeney, 2011). Frameworks require, furthermore, collaboration and the sharing of information between key agencies (Stevens, 2013).

With such matters in mind increasing attention has been given over more than a decade to the matter of surveillance and the way in which technologies might be used. Providing something of a prelude to this Powell and Biggs (2000) explored the way in which power, including measures of surveillance, is exercised by state institutions in shaping a somewhat imbalanced ‘welfare discourse’. Lyon (2001) has noted that the use of technologies for surveillance involved ‘care and control’ but also carried a wider potential that could ‘enable’. Fisk (2003) argued that surveillance could ‘give reassurance’ to those who might be fearful of falling, illness or emergencies. And, more broadly, Bernard and Phillips (2000) suggested that technology should be ‘at the heart of social policy’. More recently the growth in the use of technologies in the context of care has been recognised by Demos (2014), their report specifically noting the role of telecare and telehealth - with the former having the ability ‘to monitor people’s activities and conditions’ leaving care staff ‘freer to focus on relationship building’.

With regard to the current debate the consultation for England undertaken by the Care Quality Commission (CQC) is particularly noteworthy. This led to the issuing of guidelines regarding both covert and overt surveillance for health and social care service providers (Care Quality Commission, 2014) and separately to family members or others who might be thinking of using ‘hidden cameras or other equipment’ to monitor the care received by a ‘loved one’ (Care Quality Commission, 2015). For health and social care providers the CQC advised that the use of cameras should accord with data protection requirements and take place following legal advice. The decision, they affirmed, ‘whether to use surveillance is for [them] to make in consultation with the people who use their services, and with families, carers, trade unions and staff’ (Care Quality Commission, 2014). For family members they opined that it was ‘a decision for people and families to make’ but pointed to the, as yet, unclear legal position; the requirement for consent; and the potential impact on the

privacy of others 'who use the service, staff, families and visiting professionals' (Care Quality Commission, 2015). No mention was made, in either of the guidelines, of the potential use of such technologies to capture examples of good care, its ability to provide a record of falls, or its potential to act as an independent witness in a way that could protect care staff as well as residents.

Taken together it is clear that whilst there is a small nod in the sets of guidelines towards the freedom of both service providers and family members to use surveillance technologies, the CQC is reluctant to take a clear position and demurs, therefore, from setting out any framework within which their effective use can be supported and controlled. That reluctance links, in essence, to legal questions and to concerns around privacy. The concern about privacy echoes the perspective of Stephen Burke who emphatically argued in Guardian Professional on 8th October 2014 that cameras 'invade older people's privacy' and undermine the role of care workers.

Finally in this brief introduction to the 'UK Debate' it must be noted that the terms surveillance and monitoring are interchangeable. The CQC (2014) noted that 'surveillance is the monitoring of a place, person, group or ongoing activity in order to gather information'. Biggs and Powell (2000) suggested more bluntly that surveillance equals 'inspection minus intervention'.

The HC-One Consultation and the GMB Survey

Some care home providers are exploring the potential or experimenting with the use of surveillance technologies. One of these is HC-One which manages one of the care homes featured in the Panorama exposé. Overall it manages over 200 care homes in the UK that were originally part of the Southern Cross Group. HC-One consulted with staff, residents and family members about 'visible cameras' as 'safeguarding tools'. Further work is planned by them with 'key external organisations and interested parties' in order to obtain additional feedback on any implementation scheme. HC-One's initial position considered that cameras could 'act as a deterrent, helping to guard against incidents happening'. But they also noted the potential adverse impact 'on the privacy of residents' (HC-One, 2014). A parallel consultation in HC-One's care homes, summary outcomes of which are noted below, was undertaken by the GMB Union with their members in 2014.

First it is useful to examine the HC-One consultation. This achieved valid responses from over 12,000 people (see Table 1). The main question posed was, however, simplistic and begged further questions relating e.g. types of cameras and their locations. No questions were asked about audio-recording. Usefully, however, contrasting views of staff, residents and their family members were identified and other information was gathered about 'concerns' from a pre-defined range of answer choices. Privacy for residents was, unsurprisingly, highlighted as the main concern (for 74%). Most other responses followed from this – relating to who had access to images or video footage (and in what circumstances); how these were stored; and where cameras were located. A further concern was noted by 45% as to who owned images or video footage.

The HC-One consultation envisaged 'the visible camera scheme as comprising a camera in the bedroom of each resident who had opted in'. But the bedroom location of cameras was not altogether clear in the main question asked and a further question that referenced cameras 'in communal areas as well as bedrooms' may have added to any confusion. In view of this it is best to focus the comparative picture between groups of responders - this indicating that the strongest support for visible cameras (wherever located) was among family members, with varied views being evident for residents and staff. HC-One (2014) reported that 'the results were inconclusive and raised a number of additional areas for consideration'.

Table 1: Outcomes of HC-One Consultation

	Residents	Family Members	Staff	Total
Total valid responses	1536	3371	7330	12237
Would you like HC-One to offer residents and relatives an opt-in scheme for visible cameras in HC-One homes?	47% Yes	87% Yes	63% Yes	68% Yes
Do you think cameras should be placed in communal areas as well as bedrooms?	41% Yes	79% Yes	26% Yes	51% Yes

The GMB survey elicited 2,164 responses to a more varied set of questions that were more precise regarding camera locations. With regard to outcomes (excluding respondents who were unsure) 55% supported the use of cameras in communal areas, 36% in residents' rooms and 18% in staff-only areas. Overall 53% of respondents felt 'relaxed about visible cameras being installed in care homes' and 82% considered that cameras could 'help to identify and prevent abuse'. As with the HC-One consultation no questions were asked about audio-recording.

The gathering of such staff views is particularly welcome in view of their key role in providing care. The fact that nearly nine in ten staff agreed that 'cameras don't tell the whole story ... good care requires enough staff and proper training' is, therefore, very important. Echoing the finding from the HC-One consultation there were concerns among staff members regarding privacy (both for residents and for the staff themselves) and a clear agreement on the importance of consent. A selection of findings is offered in Table 2.

Table 2: Some Outcomes from GMB Survey

	Yes	No	Not Sure
I am relaxed about visible cameras being installed in care homes	42%	36%	22%
Cameras should only be introduced with the consent and knowledge of the resident and/or their family	79%	15%	6%
Visible cameras could help to identify and prevent abuse	70%	15%	15%
Visible cameras could help to protect staff against false allegations	78%	13%	9%
There would need to be clear rules about how footage from the cameras is used	92%	5%	4%
Cameras should only be used in homes where inspectors have identified problems	34%	44%	22%
Footage should only be looked at when a complaint has been made	57%	24%	19%
Only inspectors should be able to access the footage	38%	42%	20%
Cameras don't tell the whole story. Good care requires enough staff and proper training	87%	8%	6%

Note: Figures may not add to 100% due to rounding.

The HC-One consultation and the GMB survey both inform the UK debate. Their contribution is, however, only partial because they did not give consideration to the potential use of audio-recording or other forms of surveillance. With regard to this wider frame of reference it is interesting to note, therefore, that the Graham Care Group (with care homes in the South East of England) is experimenting with audio monitoring (without cameras) in residents' rooms with a view to these being shared with authorised family members. Recordings are triggered on entry by a staff member with this being complemented by activity monitoring information based on audio rather

than movement. Whether such audio recording might be regarded as potentially less intrusive than the use of cameras is not known.

Such issues relating to the combating of abuse together with the findings from the work of HC-One and the GMB have all been taken into consideration in the development of the seven principles offered in this paper. But the wider context of different kinds of surveillance technologies must first be considered.

Different Kinds of Surveillance and Related Technologies

This paper does not offer an overview of the technologies that might be found within care homes – regardless of their surveillance or ‘assistive’ roles. But recognition of this wider range helps counter any narrow focus on cameras *per se*. Many assistive technologies are already familiar within care homes and routinely used by residents and/or staff. These include walking frames, hoists, bed occupancy sensors, activity monitoring systems, special baths, automated lighting and call systems. Several of these provide us with the reference point of telecare and telehealth especially given the fact that call systems now increasingly have linked or embedded sensor devices that communicate of data, audio and visual information – notably in community settings but also in care homes. Telehealth (including telecare and call systems) is ‘the means by which technologies and related services concerned with health and well-being are accessed by people or provided for them, at a distance’ (Fisk, 2014).

These technologies are already being widely used for surveillance under the more benign term of ‘monitoring’ (Fisk, 2003). And it needs to be acknowledged that such monitoring is embedded in service approaches to sheltered housing where wardens (now generally scheme managers) make calls via the alarm system to residents; and, though their responsibility as ‘good neighbours’, they keep an eye out for opened curtains, milk being taken in, etc. Meanwhile, technological innovations around set-top boxes (increasingly incorporating cameras to enable social networking by their users); and ‘magic mirrors’ that can view e.g. the pallor, pulse and breathing rate of the person presenting themselves, may also be significant. And in hospitals surveillance is frequently the norm - with arrays of medical technologies used to monitor the vital signs of patients, and with cameras increasingly used in operating theatres and common areas as well as (as noted by Denis Campbell in *The Guardian* of 8th May 2012) being trialled on the wards.

A duty of surveillance is therefore part of the role of many care staff where such technologies are used; and is arguably in place for *all* care staff. By accepting this we can start a more meaningful debate around questions of privacy and how the use of surveillance technologies impacts on this. With such questions in mind and given the positive views of many family members regarding the role of cameras (evidenced in the HC-One consultation) it is clear that answers must quickly be found if their *ad hoc* use in care homes, regardless of the Care Quality Commission (2015) guidelines to family members, is to be minimised.

The HC-One report touched on some of the issues (HC-One, 2014) but a broader perspective is now necessary. Useful is the notion of ‘intelligent monitoring’ as put forward by Padilla-Lopez et al (2014). This points to the fact that the extent of intrusiveness of surveillance technologies (and the impact on privacy) is in part determined according to the way that cameras ‘see’. In other words the issue is less to do with the use of cameras, but rather, the ways in which images or video footage are processed. With such processing in mind, consideration of the role of cameras can be repositioned around the way in which images and video footage, together with any linked audio, is captured and processed - prior to any occasion where, if at all, they are accessed.

This repositioning is, in part, facilitated because of the potential for transforming images or video footage through blurring or pixellation; and/or the rendering of images as skeletal or as silhouettes. By controlling access to such images different levels of privacy can be put in place (Padilla-Lopez et al, 2014). There is, therefore, no necessity to envisage the viewing of 'raw' images unless there are very special reasons for so doing. At the same time various conditions can be firmly in place to ensure that any impact on privacy is minimised. Our attention can, therefore, be addressed more to the levels and nature of authorised viewing rather than the appropriateness or not of the use of cameras. Such viewing would, in any case, at most, be likely to be occasional with most of the footage gathered being erased unseen. Similar approaches would apply to listening to audio recordings.

The Central Ethical Dilemma

As noted, surveillance at some level is accepted care practice. Aspects of surveillance are, therefore, arguably a social good – especially if key outcomes relating e.g. to empowerment and inclusion can also be pointed to. If we permit or encourage higher levels of surveillance in care homes, therefore, its legitimacy may depend on the framework within which it takes place and the extent of the additional benefits (outcomes) that it may confer. Linked with this is the need to consider the role and actions of staff, the functions and usage of the technologies themselves, and the extent to which actions that relate to surveillance are ethically appropriate.

One ethical touchstone for care is recognised as the four principles set out by Beauchamp and Childress (2007). These principles of autonomy, beneficence, nonmaleficence and justice have much to their merit. But when safeguarding needs are considered, questions arise as to the extent to which autonomy is in fact being realised in care contexts where people might be particularly vulnerable and whose ability to give consent may be compromised because of diminished capacity.

Noting that care provision was increasingly provided for people with diminished capacity, Sorell (2011) affirmed that 'autonomy and competence can only be assumed in a cognitively normal range.' This does not, it must be stated, absolve us from any duty to *promote* autonomy even for those outside that normal range; but it does give us permission to consider surveillance technologies in accordance with a wider notion of people's 'best interests'. In Sorell's words 'autonomy might be an aim of human life in general, but it does not follow that human beings should always be treated as autonomous.'

In reconsidering our ethical benchmarks we could go further. Tronto's 'ethics of care' are concerned with attentiveness, responsibility, competence and responsiveness. They require care staff to 'see' or to 'notice', to attend and to respond (noted in Ash, 2014). Cameras, we posit, along other surveillance technologies, can provide some of that 'seeing' or 'noticing'. So does the sharing of information between agencies concerned with safeguarding so that they might 'notice' and take appropriate actions or rethink care plans, policies and practices (Stevens, 2013). In summary, therefore, we can point to surveillance technologies as posing an ethical challenge because they could compromise autonomy but at the same time they may, per Sorell (2012), support beneficence.

Finally, on a more practical level relating to the use of cameras, Padilla-López et al (2014) noted three stages at which privacy protection might be involved. These are extended to six as follows:

- consent;
- image or video footage transmission;
- storage of image or video footage;

- sharing of or access to images or video footage;
- image or video processing; and
- image or video footage erasure.

The key point is that whilst we have significant ethical dilemmas we also have a growing range of technologies that can be positioned, calibrated and used in different ways. The manner in which this takes place can determine the way in which privacy is protected and ethical dilemmas resolved.

Seven Principles for the Use of Surveillance Technologies

Seven principles for the use of surveillance technologies in care homes are set out below. They offer a framework for the adoption and use of such technologies in care homes; and they help to respond to the concerns of the Care Quality Commission. The principles focus on overt surveillance - with covert surveillance being considered as only appropriate when required by an appropriate regulatory or legal body. They recognise that the potential for privacy to be compromised is greatest where personal tasks are often undertaken i.e. the bathroom or bedroom. They acknowledge, furthermore, that abuse can take place anywhere - this justifying consideration of the use of surveillance technologies in *all* areas of care homes, albeit that protocols and procedures will vary.

Adoption of the principles offers a means by which surveillance technologies in care homes, including cameras, can be permitted or encouraged as a standard requirement. Some further work is nevertheless needed to provide discussion around the principles and to ensure that both legal and rights issues are satisfied before detailed procedures and protocols can be developed.

Principle 1: Any reasonable level of surveillance (including cameras) is appropriate for common or public areas in care homes.

Care homes should determine the desired extent of surveillance in common or public areas and be clear about this in their dealings with residents, family members, staff, carers and regulatory bodies. Surveillance should be overt. Clarity about this would be required within promotional literature, supporting information and contract documents.

This principle reflects the view that surveillance is legitimate in care homes and is potentially beneficial. Care homes must carry responsibility for the maintenance and proper working of such technologies.

Principle 2: Care homes should be able to provide or should be willing to permit or facilitate, the use of surveillance technologies (including cameras) within a resident's room or other private areas.

The nature of the consent required for such usage will necessarily take account of the resident's capacity and involve appropriate others (normally family members). The consent may be part of the contracted agreement by which a resident comes to the care home. It should take account of the residents' rights (per the 1998 Human Rights Act) to a 'reasonable expectation of privacy' and regarding the treatment of information, including photographic material, about them.

This principle acknowledges the importance of consent. It allows for surveillance in bedrooms and bathrooms but demands that very careful consideration is given to the way in which images, audio or video-footage are treated. It also requires that attention is given to the rights of both residents and family members.

Principle 3: The location of surveillance technologies should be carefully considered. They should be visible or otherwise clearly known to be present.

Whilst it is appropriate to consider the way in which surveillance technologies fit within the decor of a care home (including resident's rooms) they must remain visible or clearly pointed to. The levels or types of lighting should be such that the technologies are able to fulfil their primary purpose.

This principle reflects the importance of ensuring that approaches to surveillance are effective. It also recognises the extent to which cameras or other devices may be embedded in e.g. light fittings, clocks or mirrors.

Principle 4: Staff should be fully aware of their responsibilities in relation to surveillance technologies.

The responsibilities of staff, contractors and others should be made clear (potentially built into their contracts) so that effective use of surveillance technologies is not compromised. They should be aware that their conduct is able to be monitored through such technologies but that this same monitoring can provide protection for them and a record of good care practice.

This principle acknowledges the importance of staff understanding how the use of surveillance technologies can act as a safeguard both for residents and for themselves.

Principle 5: Access to data, images, audio or video footage should be restricted only to authorised persons or agencies in particular, defined circumstances.

Clear safeguards should be in place regarding who is and who is not able to access information gathered through the use of surveillance technologies. Access at appropriate levels would, for instance, be permitted to authorised people who were undertaking safeguarding investigations.

Linked with this is the need to determine the level of access (limited, for example, to audio or to images with pixellation), depending on the circumstances but with a process for escalation to other levels where this is clearly justified. There would need to be unequivocal audit trails to identify who, at what time, at what level and for what purpose, had access. Defined circumstances in which access by an authorised person or agency could be undertaken as routine might include where the resident has fallen or thefts may have occurred.

This principle acknowledges the acute sensitivities around access to data, images, etc. Pursuit of this principle might be helped through the use of a suitable external body to ensure appropriate control over the data, images, audio and video footage.

Principle 6: Ownership of data, images, audio or video footage.

Data, images, audio or video footage should be treated as if owned by the resident but where it is gathered, held and used for his/her benefit. Such treatment should not, however, mean that it can be accessed or acquired by the resident or appropriate others – except in specific circumstances that may require legal authority. Those data, etc., except in exceptional circumstances, should be fully erased after a pre-defined period after departure or death of the resident.

This principle acknowledges the primacy of the resident (and, where appropriate, family members) and the importance of protecting data, images, etc. pertaining to them. It follows that while residents or appropriate others may have given consent for the use of surveillance technologies there needs to be a procedure where, at their request (e.g. when with trusted visitors), such use may be temporarily suspended.

Principle 7: Minimising Intrusion

Consent given for the use of any surveillance technologies with the potential to intrude excessively on an individual's privacy should always be subject to approval by the appropriate regulatory agency.

This principle recognises the extent to which privacy can be compromised by some approaches to surveillance. The intrusion concerned can be considered in relation to criteria noted by Fisk (1997) including the prior experience of the technology by the user; the characteristics of the equipment; the extent to which the user has control over the technology; and any compensatory effects or associated other benefits.

This points to considerations by which the dilemma relating to duty of care versus autonomy can, with careful judgement, be resolved.

Conclusion

This paper addresses some of the concerns and dilemmas regarding the use of surveillance technologies (including cameras) in care homes. It argues that their use can be ethically justified and points to the fact that such use is established practice in some areas of care. An approach is offered that enables a broad range of surveillance technologies to be considered. Seven principles have been offered to assist in this process.

The attempt made in this paper to widen the debate away from a narrow focus on cameras is valid. And given the significant public concern about abuse, further work concerned with the potential of technologies in the context of safeguarding, becomes essential. The manner of the use of surveillance technologies, however, should acknowledge both the existence of a permissive ethical framework and the potential of such technologies to both safeguard and enable people.

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Corresponding Author

Dr Malcolm J. Fisk can be contacted at mfisk@cad.coventry.ac.uk